OrthoCareGlobal

Heilstättenweg 1, Ganderkesee, Germany 27777

IMPORTANT: Please fill out this form completely. It contains information that is critical for your consultation. Failure to complete the form will result in a delay in your consultation.

2 WAYS TO COMPLETE:

1) This form is designed so you may easily complete it on your computer. You can complete the fields below and save the file to your computer for submission.
2) If you prefer, you may instead print out this form and complete it by hand. You will then need to scan the completed document and save it on your computer for submission.

*If you are unable to type directly into this document: 1) Save this document to your desktop. 2) Download and install Adobe Acrobat Reader from **HERE** (You can skip any "additional offers.") 3) Close this document and reopen it from your desktop. The file should open in the proper version of Adobe Reader and be editable.*

PERSONAL DATA

Full Name _____ Birthdate / Age _____

Address _____

Phone _____ Email _____

Height _____ Weight _____ Occupation _____

IF YOU ARE A CANDIDATE FOR SURGERY WHAT MONTH IS BEST FOR YOU?

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July
☐ August ☐ September ☐ October ☐ November ☐ December

HOW DID YOU LEARN OF US?

☐ Web-site ☐ Friend ☐ Doctor ☐ Referral ☐ Book ☐ Advertisement
☐ YouTube ☐ Facebook ☐ Other _____

PAIN HISTORY

Length of time	
Describe numbness, weakness, neurological deficits, leg pain (if any, left/right/both)	
What makes pain worse?	
Walking tolerance (minutes or distance)	
Standing tolerance (minutes)	
Sitting tolerance (minutes)	
Previous spine surgeries	
Other surgeries	
Medications (spine related)	
Medications (other)	
Allergies (medications, metals, etc?)	

Please advise if you are taking Fentanyl or morphine patches. We supply standard pain management but not these specifically. These and other medications that are non-pain related should be brought with the patient.

PAIN HISTORY

(ACCIDENTS, EVENTS REQUIRING VISIT TO DOCTOR, CONSERVATIVE TREATMENT FOR SPINE PROBLEM ETC.)

Event	Date	Data/Films	Description

PERSONAL MEDICAL HISTORY (ANSWER YES/NO. DETAIL IF NECESSARY)

Cardiovascular diseases	
Blood pressure/ hypertension	
Stroke	
Heart trouble	
Irregular heartbeat	
Blood clots/ embolism	
Respiratory system	
Nose throat problem	
Breathing problem	
Chest pain	
Asthma	
Pneumonia	
Tuberculosis	
Hormonal / metabolic diseases	
Diabetes	
Thyroid problem	
Diseases of the nerve system	
Migraine headache	
Nervous breakdown	
Eye problems	
Epilepsy	
Depression	

PERSONAL MEDICAL HISTORY CONTINUED (ANSWER YES/NO DETAIL IF NECESSARY)

Gastrointestinal tract/organs	
Stomach problem	
Pyrolysis	
Colitis	
Hepatitis / Jaundice	
Kidney problems	
Infectious diseases	
AIDS positive	
Hepatitis	
Blood diseases / Anemia / Transfusion	
Bleeding problem	
Transfusion	
Anemia	
Joint / bone diseases	
Lupus	
Arthritis	
Back problems (other)	
Osteoporosis	
Cancer	
Details	

HABIT DETAILS (PLEASE NOTE ALL INFORMATION IS STRICTLY CONFIDENTIAL)

	Consumption (daily, weekly, etc.)
Alcohol	
Cigarettes	
Drugs (Cannabis, etc.)	
Homeopathic	
Other	

CASE HISTORY – WORK INVOLVEMENT AND LEISURE TIME ACTIVITIES

The physical strain in job and leisure time plays a major role for orthopedic diagnosis and therapy. This questionnaire will therefore help us to help you.

1. What is the profession you work in? _____

2. Have you had to stop working or change jobs because of your condition? ☐ Yes ☐ No

If yes, when? _____

What job are you working in at present? _____

3. You are working under these conditions.

Fulltime ☐
Part-time ☐
A few hours per day ☐

4. Is your job physically straining for you? ☐ Yes ☐ No

Is it associated with monotonous body postures? ☐ Yes ☐ No

Does your status make it difficult to work? ☐ Yes ☐ No

5. Do your complaints allow you to do sports? ☐ Yes ☐ No

If yes, what kind of sports are you doing? _____

Did you do any sports before? ☐ Yes ☐ No

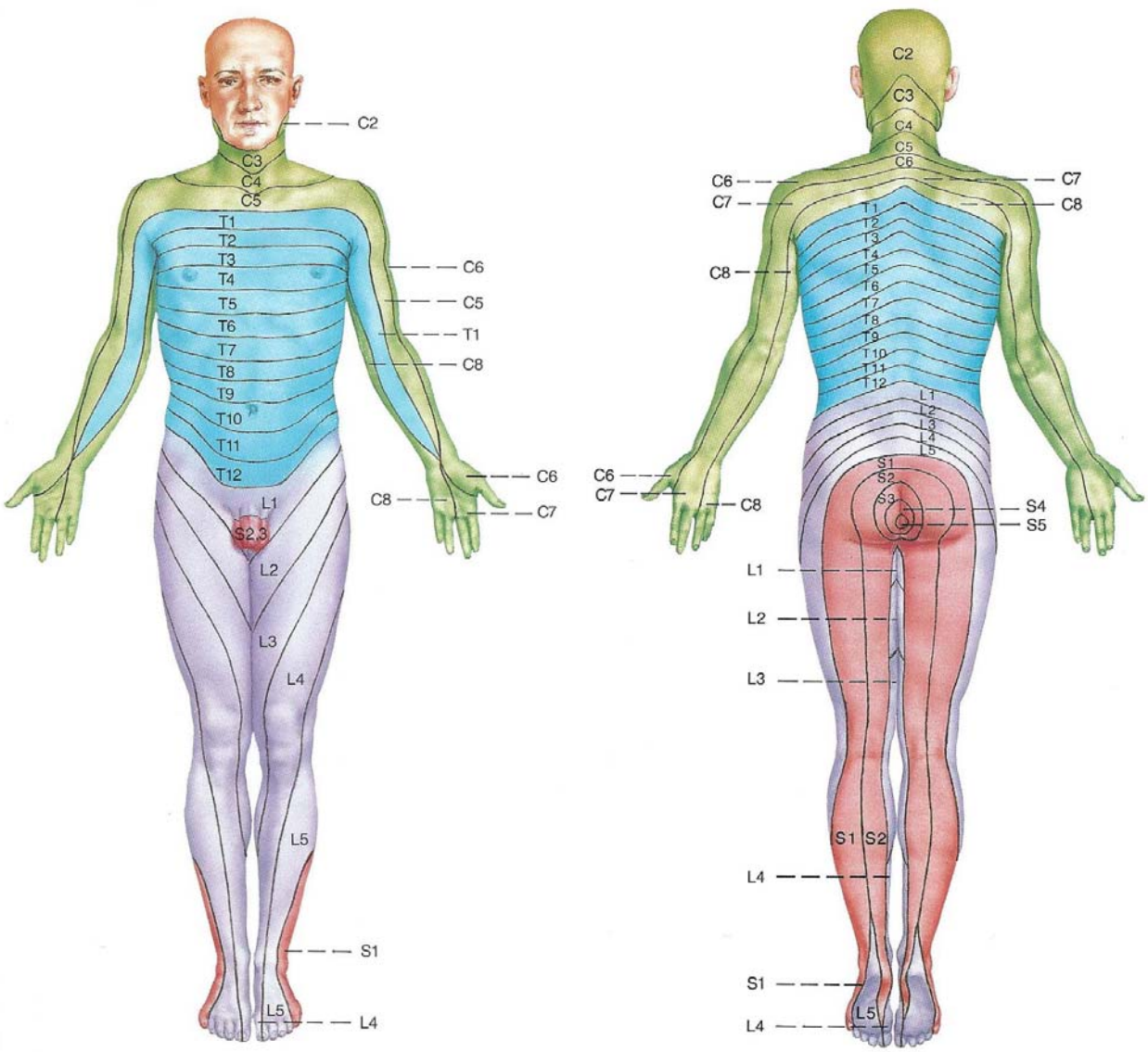
If yes, what kind of sports? _____

6. Will you have someone to support you at home after surgery? ☐ Yes ☐ No

Who would help you? _____

BODY SCHEME

Please mark the pain area and mark the sensations according to the legend below.



Legend:

n = numbness

t = tingling

w = weakness

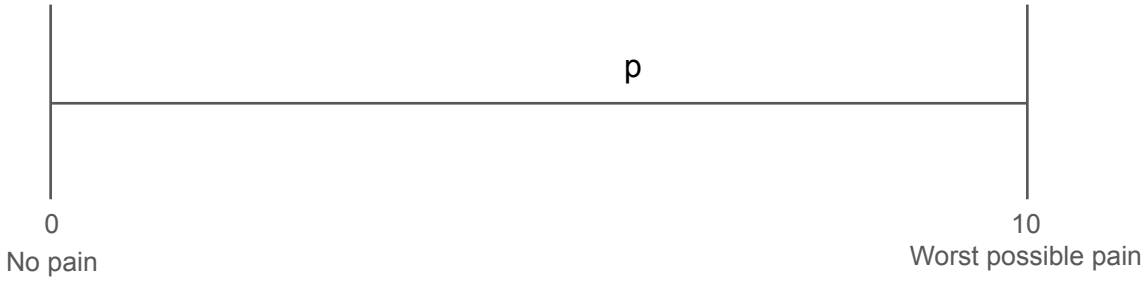
b = burning

VISUAL ANALOGUE SCALE / BACK

During the past 4 weeks , how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

The visual analog scale is a horizontal straight line with the left end of the line representing no pain and the right end of the line representing the worst possible pain. Please make a mark on each line that represents the intensity of the pain in your back, in your left leg and in your right leg. The first line is an example of how to make the mark on the line.

Example:



Back Pain:

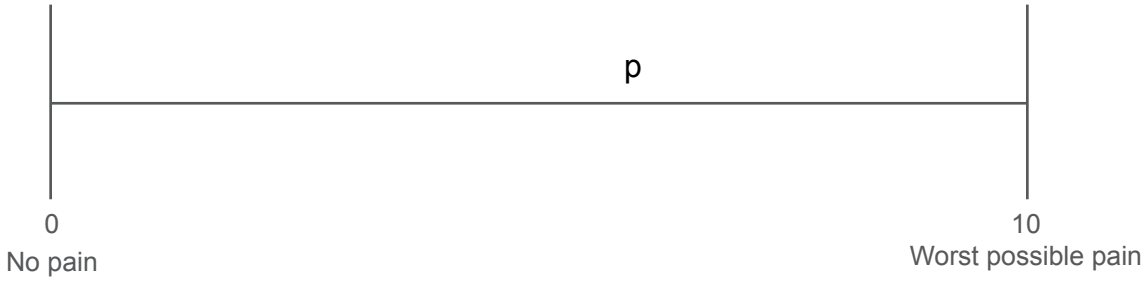
Left Leg Pain:

Right Leg Pain:

VISUAL ANALOGUE SCALE / NECK

The visual analog scale is a horizontal straight line with the left end of the line representing no pain and the right end of the line representing the worst possible pain. Please make a mark on each line that represents the intensity of the pain in your back, in your left leg and in your right leg. The first line is an example of how to make the mark on the line.

Example:



Neck Pain:

Left Arm Pain:

Right Arm Pain:

During the past 4 weeks , how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. Compared to one year ago, how would you rate your health in general now?

Much better now	Somewhat better now	About the same	Somewhat worse now	Much worse now
☐	☐	☐	☐	☐

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a) **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b) **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c) Lifting or carrying groceries	☐	☐	☐
d) Climbing **several** flights of stairs	☐	☐	☐
e) Climbing **one** flight of stairs	☐	☐	☐
f) Bending, kneeling, or stooping	☐	☐	☐
g) Walking **more than a mile**	☐	☐	☐
h) Walking **several blocks**	☐	☐	☐
i) Walking **one block**	☐	☐	☐
j) Bathing or dressing yourself	☐	☐	☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a) Cut down on the **amount of time** you spent on work or other activities	☐	☐
b) **Accomplished less** than you would like	☐	☐
c) Were limited in the **kind** of work or other activities	☐	☐
d) Had **difficulty** performing the work or other activities (for example, it took extra effort)	☐	☐

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
a) Cut down on the **amount of time** you spent on work or other activities	☐	☐
b) **Accomplished less** than you would like	☐	☐
c) Didn't do work or other activities as **carefully** as usual	☐	☐

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

7. How much bodily pain have you had during the <u>past 4 weeks</u>?

None	Very mild	Mild	Moderate	Severe	Very severe
☐	☐	☐	☐	☐	☐

8. During the <u>past 4 weeks</u>, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	A Good Bit of the Time	Some of the time	A little of the time	None of the time
a) Did you feel full of pep?	☐	☐	☐	☐	☐	☐
b) Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
c) Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
d) Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
e) Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
f) Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
g) Did you feel worn out?	☐	☐	☐	☐	☐	☐
h) Have you been a happy person?	☐	☐	☐	☐	☐	☐
i) Did you feel tired?	☐	☐	☐	☐	☐	☐

During the past 4 weeks , how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

11. How TRUE or FALSE is <u>each</u> of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a) I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b) I am as healthy as anybody I know	☐	☐	☐	☐	☐
c) I expect my health to get worse	☐	☐	☐	☐	☐
d) My health is excellent	☐	☐	☐	☐	☐

Optional notes:

DIGITAL SIGNATURE: By typing my full name below, I signify that the information on this form is true and correct to my knowledge

Full Name: _____ Date - / - / -

IMPORTANT: Please make sure you have filled out this form completely before submission. Incomplete information may delay your consultation.

SAVE THIS FORM: Save this completed form to your computer. Click "File" from the menu at the top of the screen and then "Save As" to save this file in a location where you will easily find it. It is recommended you change the file name to include your name like this: FirstName LastName Patient Data Sheet.

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